[COMMITTEE PRINT]

AMERICA'S UNINSURED AND UNDERINSURED: A NATION AT RISK OF INADEQUATE HEALTH CARE AND CATASTROPHIC COSTS

A REPORT

PRESENTED BY

THE CHAIRMAN

OF THE

SELECT COMMITTEE ON AGING

HOUSE OF REPRESENTATIVES

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EXECUTIVE SUMMARY

Health insurance coverage for 235 million Americans of all ages is a deep and immediate concern to Congress because it is an essential element if people are to access needed health care and reduce the personal burden of catastrophic health costs. Every day, personal tragedies are hitting not only millions of individuals with catastrophic illnesses but their families as well.

The Uninsured and Underinsured. Studies continue to document serious gaps in health insurance coverage. Over 31 million persons -- over 13 percent of Americans -- are **uninsured.** Of equal concern are the many millions who are **underinsured** -- those whose existing insurance coverage is inadequate. The underinsured are also not assured of access to needed health care, be it primary, acute or long term care, nor are they protected from catastrophic health costs. Over 85 percent of Americans are underinsured against catastrophic health costs.

The Uninsured and Underinsured at Risk. For the uninsured and underinsured, the risk is great and growing. One million families have at least one family member who was refused care because of inadequate funds. Up to 10 percent of families face health costs in excess of 10 percent of income. When facing a catastrophic acute or long term illness, over 200 million Americans are underinsured. Sadly, the risk is growing. As one example, the elderly, on the average, face paying as much as 18.5 percent of their income for health care by 1991 -- significantly higher than the 12.3 percent paid in 1977.

Options for Insuring the Uninsured and Underinsured. Fortunately, there is no shortage of options for insuring the uninsured and underinsured. For those who argue that **private sector options** should be the primary or only options used, they cite approaches such as having employers extend and expand coverage, instituting medical IRAs or health savings accounts, allowing expanded tax deductions or credits, or encouraging insurance companies to make catastrophic insurance policies available. What must be kept in mind is that these private sector options serve to decrease federal revenues and do not directly address the problems of the medically indigent and others with limited ability to pay.

By applying theses criteria, the American people and policymakers can judge the adequacy and merits of each health insurance proposal offered.

Commitment to Insuring the Uninsured and Underinsured. Uncertainty may exist about the extent of public support for active government leadership. However, the public, fostered by the growing personal experience with inadequate health care coverage, is making increasing demands that goverment address this crisis.

The federal government, in conjunction with States and the private sector, has the responsibility and must make the commitment to act as the steward of the nation's health care delivery system and the protector of the nation's health. Government should shoulder the responsibility and can take the lead in ensuring equity of access. "Equal access" is far too important a matter to be left to chance or to whim or to "market forces."

Now is the time to make the commitment to protect the uninsured and underinsured. The risk to the uninsured and underinsured is great and grows every day. High and rapidly rising health costs are hitting Americans of all ages, incomes and types of illness. If costs are not controlled, health costs for everyone -- individuals, employers, government -- will outdistance our ability to pay. We no longer can afford not to act.

However, public and private sector policymakers will not solve the problem unless and until Americans of all ages demand that it be done. When public policymakers believe that elections will be won or lost on this issue, then and only then will this catastrophic problem of over 31 million uninsured and over 200 million underinsured Americans be solved.

For those arguing that **public sector** options should be the primary or only options used, alternative approaches include extending the Medicaid program, purchasing private insurance, allowing low income individuals to "buy" into Medicaid, developing private "risk pools" where individuals could buy insurance at group rates, creating "bad debt and charity pools" for hospitals, and using grant programs such as the community health center and maternal and child health programs. At the federal level, public options include extending the eligible Medicare population or expanding coverage to include catastrophic acute and long term care, instituting voucher-type systems, or providing services directly as in the Veterans Administration and the Indian Health Service.

A more ambitious and comprehensive federal public insurance option might protect all Americans (including the fully insured, the uninsured, and the underinsured), cover health and long term care, shield Americans from catastrophic acute and long term care expenses, upgrade the quality assurance system and contain total health care costs. One such comprehensive health protection package is the Chairman's proposed "USHealth" program.

Criteria for Assessing the Options. As we consider the available options, it is important to keep in mind that all funding comes from the same source, the American people. How much Americans pay depends heavily on their health status and insurance coverage and, unfortunately, much less on their ability to pay. The challenge is to create a health insurance system which ensures equal access even for those Americans with limited ability to pay for needed care.

In choosing among the options for ensuring equity of access for all Americans or in packaging a more comprehensive solution, certain criteria should be applied:

- Are the uninsured fully insured?
- Are the underinsured insured for basic health costs?
- Are the underinsured insured for catastrophic acute care costs?
- Are the underinsured insured for catastrophic long term care costs?
- Is the quality of health care assured?
- Are costs affordable for individuals, government and employers?

AMERICA'S UNINSURED AND UNDERINSURED: A NATION AT RISK OF INADEQUATE HEALTH CARE AND CATASTROPHIC COSTS

Health insurance coverage for 235 million Americans of all ages is a deep and immediate concern to Congress because it is an essential element if people are to access needed health care and reduce the personal burden of catastrophic health costs. * Recent studies continue to document serious gaps in insurance coverage. **Over 31 million persons -- more than 13 percent of the U.S. population -- are uninsured, highlighting the need for some type of remedial action. Of equal concern are the many millions of Americans who are underinsured -- those whose insurance is inadequate.** The underinsured are also not ensured access to needed health care, be it primary, acute or long term care, nor are they protected from catastrophic health costs. **When faced with a catastrophic acute or long term illness, over 200 million Americans are potentially underinsured.**

THE UNINSURED

Any effort to estimate the number of **uninsured** people is difficult due to the lack of a satisfactory data gathering system. As a result, the following current estimates of the uninsured are low since they miss significant numbers of uninsured.

* Access is defined as the ability to pay for services, the availability of services, and the absence of other barriers. This report focuses on the ability to pay issue.

The U.S. Census Bureau's Survey of Income and Program Participation (SIPP) taken during the third quarter of 1985 revealed that **approximately 13.5 percent of Americans, representing 31.8 million persons, are without health insurance -- public or private.** The uninsured are, by and large, people under age 65, as the Medicare program provides coverage for the elderly. About 150,000 people over age 65 are uninsured. The 16 to 24 age group contains the largest proportion of uninsured with over 22 percent lacking insurance. Sixteen percent of those under the age of 16 are without insurance.

The SIPP survey shows that of those under 65 years of age, about 15.2 percent are uninsured. To give some historical perspective to this statistic, 12.5 percent of people under age 65 were uninsured in 1977. (National Medical Care Expenditure Survey (NMCES), 1977) This proportion rose to a high of 17.1 percent in 1983. (SIPP, 1983)

The Employment Factor. **Approximately 75 percent of the uninsured are employed adults or their dependents.** The employed uninsured tend to be young and relatively less educated. Workers in occupations that are seasonal or transitory in nature and those in occupations requiring relatively less technical skill are also more likely to be uninsured. (National Center for Health Services Research, 1985)

The Poverty Factor. Although the uninsured are distributed across income levels, a disproportionately large share are economically disadvantaged. According to the 1982 Current Population Survey, **35 percent of the uninsured have a family income below the federal poverty threshold of $9000 for a family of four; 64 percent (nearly two-thirds) of the uninsured have a family income below 200 percent of the federal poverty standard.**

The Geographic Factor. The likelihood of being without health insurance appears, to some extent, to be a function of geographic region of residence. **Two-tenths of the residents of the West South Central states are uninsured, whereas, only one in ten residents of New England are uninsured.** Some of this variation is directly related to the varying adequacy of state eligibility criteria of Medicaid programs. (Congressional Research Service, 1986)

The Medicaid Factor. Medicaid deserves much credit for improving the poor's access to health care. However, many poor persons are not eligible for Medicaid coverage. Poor people may not qualify for Medicaid either because they don't meet the categorical requirements (i.e. they aren't aged, blind, disabled, or eligible for Aid to Families with Dependent Children) or because they don't meet the state-determined resource and income requirements. This latter problem is exemplified by the fact that the cut-off income level for Medicaid eligibility dipped below 55 percent of the federal poverty threshold in 23 states in 1984. (Marion Lewin and Lawrence Lewin, Business and Health, September 1984)

According to a 1982 study, only 37.5 percent of those -- both aged and nonaged -- with incomes below the federal poverty standard are actually eligible for Medicaid. Another 13.2 percent of those with incomes below the federal cut-off level are covered by employer-provided health insurance, **leaving 49.3 percent of the federally-certified poor without any form of public or private health insurance.** (Thomas Joe, Judith Meltzer, and Peter Yu, Health Affairs, Spring 1985) These are the people who fall through Medicaid's cracks.

The Uninsurable Factor. Included in the group of persons who are uninsured are persons who are not covered by a group health plan and cannot purchase private health insurance because of preexisting medical conditions. This group also includes many insured Americans who have very restricted coverage due to one or more serious health problems. President Reagan's Health Policy Advisory Group estimates that **"perhaps one million Americans are uninsurable .... totally or for specific conditions."**

THE UNDERINSURED

The many millions of Americans who have inadequate health insurance -- the **underinsured** -- are also a major public policy concern.

Estimates of the underinsured are determined by examining the extent to which payments of out-of-pocket health costs affect a family's financial well-being. Even for those with health care coverage, the out-of-pocket costs, as a result of premiums, deductibles, and copayments as well as payment for noncovered services, can reach catastrophic levels or preclude persons from seeking needed care.

A recent National Center for Health Services Research (NCHSR) study suggests that "two distinct types of families have out-of-pocket expenses that are relatively high in relation to income: (1) families which, due to high-cost illness, incur total health care bills so large that in spite of relatively good insurance coverage, the uncovered portion paid out-of-pocket amounts to a considerable sum; these are the intended beneficiaries of most traditional stop-loss catastrophic health insurance proposals; and (2) families for whom relatively small out-of-pocket expenses represent a high percentage of their income due to a combination of low income and inadequate health care coverage."

Depending on the way "underinsured" is defined, estimates of the proportion of the privately insured under age 65 who are inadequately insured range from 8 percent to 26 percent. **In general, about 13 percent are thought to be underinsured for acute illnesses.** However, the percentage who are underinsured for catastrophic acute or long term illnesses is much higher -- **more than 85 percent of all Americans.** According to the NCHSR report, between one-third and two-thirds of all nongroup enrollees are underinsured. Group enrollees, who represent 90 percent of persons with private insurance, are still a substantial majority of the underinsured.

The Catastrophic Cost Factor On the problem of catastrophic health costs, the NCHSR study shows that the families with a high ratio of out-of-pocket expenses to income were found to be headed by someone under 18 or over 65 years of age, not employed, and with lower income. The proportion who are underinsured is highest when it comes to catastrophic protection -- insurance against the small possibility of large uninsured expenses from a costly illness. **More than 200 million Americans - over 85 percent of Americans - lack adequate protection against catastrophic acute or long term care costs.**

The High and Rising Cost Factor. Already individuals and employers are having difficulty paying the high cost of adequate health insurance. Even for people who might be able to afford adequate insurance and most other out-of-pocket health care costs, the future presents the problem of rapidly rising out-of-pocket costs. Elderly out-of-pocket costs are projected to rise about twice as fast as their income. Even working Americans are unlikely to keep pace. **Per capita health care costs are projected to grow at an 8.0 percent annual rate between 1985 and 1990 while the costs of other goods (Consumer Price Index) are projected to grow at a much slower annual rate of 4.8 percent.** (Health Care Financing Review, Spring 1986)

The Non-covered Acute Care Factor. Americans over the age of 65 are in a somewhat different position than Americans under the age of 65 primarily due to the availability of Medicare coverage for basic medical care. However, most elderly are still at risk, just as are the non-elderly. Medicare and most private insurance exclude payments for preventive examinations, eyeglasses, prescriptions, prosthetic devices, and foot care. Furthermore, both Medicare and most private insurance provide only the most minimal protection against catastrophic health care costs -- the most significant of which is the enormous, unpredictable, and growing cost of long term care.

One indicator of the inadequacy of Medicare coverage is the fact that about two-thirds of the elderly have chosen to purchase supplemental insurance policies. However, the supplemental insurance policies are both expensive and generally only help pay for deductibles and coinsurance for Medicare covered services. As a result, the elderly remain unprotected from the costs of dental care, prescription drugs, and long term care. Further, neither Medicare nor the private supplemental policies provide protection for expenses resulting from longer term, acute illness.

The Non-covered Long Term Care Factor. **When it comes to long term care, over 85 percent of Americans are underinsured.** Home care remains a relatively uncovered service for most Americans. Nursing home coverage provided by Blue Cross and Blue Shield, commercial insurance plans and Medicare is limited. Currently, only 16-25 private insurance companies offer long-term care insurance which is substantially more comprehensive than standard Medigap policies and which go beyond restrictive Medicare definitions for nursing care.

At a cost of $20,000 to $50,000 a year, nursing home care would be financially devastating to most people. According to a study conducted by Harvard and Massachusetts Blue Cross and Blue Shield for the Committee on Aging, **nearly two out of three elderly persons living alone will impoverish themselves after only 13 weeks in a nursing home.**

The Age 55 to 65 Factor. Inadequate private insurance is a problem particularly among those between the ages of 55 and 65. While this age group is more likely to be insured throughout the year than the rest of Americans, they face the likelihood of high medical expenditures at an age of reduced employment, reduced income and lower rates of group insurance enrollment. (NCHSR, 1985)

THE UNINSURED AND UNDERINSURED AT RISK

The risks and problems facing millions of uninsured and underinsured Americans are great and growing.

THE RISK OF INADEQUATE ACCESS. According to a 1982 Robert Wood Johnson Foundation survey on access, one million families have at least one member who was refused care because of inadequate funds. Similarly, 5.1 percent of insured families found it difficult to obtain health care in the twelve months prior to the survey. The survey also indicated that 4.8 percent of insured families needed health care in the prior to the survey but did not obtain it. **A Louis Harris survey indicated that over 8 percent of American families in 1983 did not obtain needed medical care for financial reasons.**

The National Medical Care Expenditure Survey determined that utilization patterns suggest that the uninsured may not have the access they need to medical care. The insured under age 65 receive 54 percent more physician ambulatory care than the uninsured. Further, the insured under age 65 receive almost twice as much hospital care as the uninsured.

Not only do the uninsured receive less care, but they perceive themselves to be in poorer health than the insured. The Robert Wood Johnson Foundation's 1982 study shows that **20.4 percent of the uninsured believe themselves to be in fair or poor health compared to only 13.4 percent of the insured.** Poorer health status of the uninsured indicates that more health care is needed for the uninsured, not less.

THE RISK OF CATASTROPHIC HEALTH COSTS. Catastrophic costs refer to large, unaffordable, out-of-pocket health care expenditures that can result from illnesses requiring either acute or long term care. In determining whether or not a person's medical expenses are catastrophic, either a person's medical expenditures can be measured against a specific dollar threshold amount or measured relative to an individual's income.

A recent National Center for Health Services Research study documented the number of families with high out-of-pocket health care expenditures relative to income in 1977. **Of all families, 19.9 percent incur out-of-pocket costs for personal health services exceeding 5 percent of income; 9.6 percent have health care costs in excess of 10 percent of income; and 4.3 percent have health costs in excess of 20 percent of income.**

Another indicator of the inadequacy of coverage is the fact that elderly Americans will be spending just over 16 percent of their income on health care in 1986, averaging $1,850 per person. **Older persons now pay a larger portion of their income for health care than they did when Medicare and Medicaid began 20 years ago.** (House Select Committee on Aging, 1986)

Since the previous figures are based solely on out-of-pocket expenses actually paid, they likely underestimate the problem. These figures fail to incorporate costs for those services that were needed but were not sought by or provided to the uninsured and underinsured.

THE GROWING RISK FOR THE UNINSURED AND UNDERINSURED. The impact of non-existent or inadequate insurance on access to needed care is expected to grow even stronger as health care costs continue their upward spiral. As health care costs rise rapidly, it is less likely that Americans can pay the out-of-pocket costs and more likely that access is restricted.

Rising Costs. In the case of the elderly, the House Committee on Aging estimates that **out-of-pocket costs will grow from 12 percent of elderly income in 1977 to 18.5 percent in 1991.** By 1991, elderly out-of-pocket costs are projected to average $2633 per person and to amount to about 40 percent of total elderly health care costs. For the total population, the situation will also get worse as health expenditures continue to rise faster than the Gross National Product, a measure of the nation's ability to pay.

Changing Employer Behavior. Employers -- the primary purchasers of private health care coverage -- are increasingly becoming "prudent buyers" and are beginning to shop for the least expensive providers of health care and encourage insurance companies to do the same. Responding to this pressure to reduce prices, health care providers are beginning to scrutinize their costs, eliminate or reduce services that do not generate an adequate level of revenues, and avoid free or discounted care for the poor and near poor.

Increasing Competition. Further exacerbating the already restricted financial access to health care is the current emphasis on "competition" in our health system. Prior to this era of "market reform" in health care, private and public health care providers provided varying amounts of free and discounted care and could recover the associated "lost" charges by shifting them onto the bills of private paying patients. But this voluntary and informal pattern of cross-subsidization of free and discounted care is becoming less available as the health system becomes more price-sensitive.

Changing Hospital Behavior. Vanderbilt University survey indicates that both private and public hospitals are taking actions to limit the amount of free care provided. In 1981 and 1982, **approximately 15 percent of hospitals adopted explicit policies and procedures to restrict care to nonpaying patients.** (Geraldine Dallek, Health/PAC Bulletin, May/June 1985)

The growing pressure to limit the amount of care provided to non-paying patients appears to be prompting a rise in the practice of "patient dumping." While data on the number of patients transferred due to an inability to pay do not exist, a study of Chicago's Cook County Hospital revealed that the number of annual transfer patients received by the hospital increased 500 percent between 1979 and 1985. (Washington Report on Medicine and Health, July 15, 1985) Similarly, a study of Parkland Memorial Hospital in Dallas, Texas indicated a 300 percent increase in the number of transfer patients received between 1983 and 1985. (Wall Street Journal, March 8, 1985)

According to the Urban Institute, even state and local governments have reduced their direct financial support for public hospitals -- what have long been considered the hospitals of last resort for the uninsured and underinsured. (Marion Lewin and Lawrence Lewin, Business and Health, September 1984) In 1985 alone, **17 state and local public hospitals closed their doors.** Furthermore, the need for subsidized care is most critical in impoverished communities where local taxpayers are less able to finance care for the uninsured poor. (Urban Institute, June 1984)

INSURING THE UNINSURED AND UNDERINSURED

"Equal access" occurs when entry into the health care delivery system is based on need rather than factors such as status of health insurance coverage, ability to pay out-of-pocket costs, or place of residence. As described earlier, most Americans do not have equal access. However, most Americans would agree that the inequities should be removed and that equal access to health care should be achieved. The key questions are how and when.

OPTIONS FOR INSURING THE UNINSURED AND UNDERINSURED. Fortunately, there is no shortage of options for insuring the uninsured and underinsured. Though there are many ways to characterize the many options, much of the current debate focuses on private versus public sector options.

Private Sector Options. Some argue that private sector options should be the primary or only options used. Here the approaches might include encouraging or requiring employers to extend coverage to more employees, retirees or laid-off workers or to expand the breadth of coverage for all employees. Another option might be to encourage personal saving for medical expenses through vehicles such as medical IRAs or health savings accounts. Another route might be to allow expanded tax deductions or credits to cover expenses such as for long term care. Yet another option is to encourage insurance companies to make more insurance policies available which cover catastrophic acute and long term care expenses. What must be kept in mind is that these private sector options serve to decrease federal revenues and do not directly address the problems of the medically indigent and others with limited ability to pay.

Public Sector Options. Some argue that public sector options should be the primary or only options used. State and federal options might include extending the Medicaid program to pick up all of the poor or the unemployed. A different approach for the unemployed might be to purchase private insurance for them. Another Medicaid alternative might be to allow low income individuals to "buy" into Medicaid. A similar option might be for States to develop private "risk pools" where individuals could buy insurance at group rates. States might tax hospitals to create "bad debt and charity pools" and permit hospitals to draw from these pools to cover uncompensated care. Another route might be to use grant programs such as the community health center and maternal and child health programs.

Looking only at the federal level, a wide range of options are available. Using Medicare as a base, federal approaches might include extending the eligible Medicare population or expanding coverage to include catastrophic acute and long term care. Some recent proposals to institute Medicare vouchers might be used to cover other people. The federal government might also provide the services directly as it does through the Veterans Administration and the Indian Health Service. A hospital-based option might be to mandate some minimum "fair share of free care" and provide enforcement through conditions for hospital licensure, certificate of need approval, participation in the Medicare program or eligibility for tax-exempt bonds.

A more ambitious and comprehensive federal public insurance option might protect all Americans (including the fully insured, the uninsured, and the underinsured), cover health and long term care, shield Americans from catastrophic acute and long term care expenses, upgrade the quality assurance system and contain total health care costs. One such comprehensive health protection package is the "USHealth" plan introduced by Chairman Roybal. (See attached summary of USHealth Act of 1986 (H.R. 5070)).

CRITERIA FOR ASSESSING THE OPTIONS. As we consider the available options, it is important to keep in mind that **all funding comes from the same source, the American people.** Funding may come directly or indirectly from the American people through individual premiums, joint employer/employee paid premiums, individual and corporate taxes or direct out-of-pocket payments to health care providers. How much Americans pay depends heavily on their health status and insurance coverage and, unfortunately, much less on their ability to pay. **The challenge is to create a health insurance system which ensures equal access even for Americans with limited ability to pay for needed care.**

Many options are available for ensuring equity of access for all Americans. In choosing among them or in packaging a more comprehensive solution, certain criteria should be applied:

- Are the uninsured fully insured?
- Are the underinsured insured for basic health costs?
- Are the underinsured insured for catastrophic acute care costs?
- Are the underinsured insured for catastrophic long term care costs?
- Is the quality of health care assured?
- Are costs affordable for individuals, government and employers?

By applying these criteria to all proposals, the American people and policymakers can judge the adequacy and merits of each one.

COMMITMENT TO INSURING THE UNINSURED AND UNDERINSURED. Uncertainty may exist about the extent of public support for active government leadership. However, the public, fostered by the growing personal experience with inadequate health care coverage, is making increasing demands that goverment address this crisis.

The federal government, in conjunction with States and the private sector, has the responsibility and must make the commitment to act as the steward of the nation's health care delivery system and the protector of the nation's health.

As has been demonstrated by the Medicare program, government can take an active role in ensuring access to millions of Americans while working closely with the private sector. Medicare has continued to mature as a major health insurance program and continues to provide leadership on cost containment and quality assurance issues. Outside of the United States, Canada has also demonstrated that government can take the leadership role in assuring health care accessibility and affordability. So too the American government can take the lead in and should shoulder the responsibility for ensuring equity of access for all Americans. **Equal access is far too important a matter to be left to chance, to whim or to "market forces."**

Major health care reforms as envisioned above are never easy, but they must be done. They can be done if we put aside our differences and recognize what is most important -- namely, protecting the American people.

Given the forces of change and the current inequities of access, now is the time to make the commitment to protect the uninsured and underinsured. The risk to the uninsured and underinsured is great and grows every day. High and rapidly rising health costs are hitting Americans of all ages. If costs are not controlled, health costs for everyone -- individuals, employers, government -- will outdistance our ability to pay for needed health care. **We no longer can afford not to act.**

Public and private sector policymakers will not solve the problem unless and until Americans of all ages demand that it be done. **When public policymakers believe that elections will be won or lost on this issue, then and only then will this catastrophic problem of over 31 million uninsured and over 200 million underinsured Americans be solved.**

The Committee on Aging would like to thank Peggy McNamara for her valuable assistance in drafting this report.

APPENDIX

USHealth

An American Healthplan

Edward R. Roybal
Chairman, House Select Committee on Aging

The "USHealth Program Act" (H.R. 5070), introduced by Representative Edward R. Roybal in 1986, is designed to control health care costs for all Americans whether they be individuals, employers or government; to maintain health care quality for all providers and patients, and to ensure financial access to health care and prevent financial disaster resulting from catastrophic illness.

Cost Containment. The health care cost containment program covers all services and patients. In the short term, the cost containment provisions include paying all health care providers prospectively where payments are developed in consultation with providers. Future increases are limited to increases in the per capita GNP. States may set up alternative payment programs. In the long term, a major vehicle for containing costs is through HMOs.

Cost sharing of 20% for health and skilled long term care and 25% for non-skilled long term care is required, but only up to the catastrophic limits described below. Cost sharing is optional for those enrolled in qualified HMOs. The poor (under 100% poverty) and those spending down into poverty are exempt from any cost sharing which prevents access to needed care.

Cost. Target cost for USHealth is approximately 12 percent of GNP for the next 25 years.

Access. Financial access is ensured by making every citizen and resident eligible for "USHealth."

Benefits. Beneficiaries are protected from the cost of catastrophic illness. Their financial risk is limited to paying coinsurance as follows: a. up to a maximum $500/person/year, pays 20% of health care and skilled nursing home and home health costs, and b. up to a maximum $1,000/person/year, pays 25% of non-skilled long term care costs. Both "maximums" are indexed to per capita growth in GNP.

Basic health benefits (similar to Medicaid "categorically needy" package) include: inpatient and outpatient hospital services, physician services, rural health clinic services, laboratory, x-ray services, EPSDT (for those under age 21), family planning (individuals of child-bearing age), preventive care, prescription drugs, physical therapy, occupational therapy, medical equipment, prosthetic devices, orthopedic shoes, nursing home services, home health services, respite care, outpatient mental health care, inpatient psychiatric hospital services, basic dental care, vision care and other medical or remedial care recognized under State law and specified by USHealth.

Quality. The current federal quality assurance system consisting of Peer Review Organizations (PRO) is upgraded to place at least as much emphasis on quality assurance as on cost containment, cover all health care providers and consumers, cover all medical services (hospital, physician, nursing home, home health), set up a national Council on Quality Assurance, and add Consumer Advisory Boards to PROs. States have the option to develop their own qualified quality assurance system. Quality assurance is also addressed by federal qualification of HMOs.

Administration. The program is entitled **"USHealth"** and managed by the USHealth Administration (currently, Health Care Financing Administration) which is independent and off-budget.

Financing. Health care cost increases will closely match increases in per capita GNP -- approximating the Nation's ability to pay. The provisions to ensure financial access for all Americans are financed as follows: the savings generated by indexed prospective payment and capitation, beneficiary cost-sharing, an expanded cigarette tax, extension of the Medicare payroll tax to all incomes, a premium paid by the elderly (approximating the "Part B premium"), an employer tax based on compensation, State revenues covering 1/2 the cost of the poor, and a surcharge on corporate and individual income taxes sufficient for solvency of USHealth.

For further information on USHealth, contact the House Select Committee on Aging at 202-226-3375.